Carleigh Zerkle
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Instructions: Choose one of the 2 case studies below to read and answer the corresponding reflection questions for that scenario. Submit to my dropbox and be prepared to discuss your responses in class.

Case 1 – Is it Okay to Change Your Mind?

A 90-year-old female, Mrs. Ruth, is admitted to hospital from home after sustaining a hip fracture. She has a history of chronic obstructive pulmonary disease on home oxygen and moderate to severe aortic stenosis. She undergoes urgent hemiarthroplasty (hip surgery) with an uneventful operative course.

Unfortunately, on postoperative day 4, the patient develops delirium with respiratory failure secondary to hospital acquired pneumonia and pulmonary edema. Her goals of care were not assessed pre-operatively. She is admitted to the ICU for non-invasive positive pressure ventilation for 48 hours, and then deteriorates and is intubated. After 48 hours of ventilation, it was determined that due to the severity of her underlying cardio-pulmonary status (COPD and aortic stenosis), ventilator weaning would be difficult and further ventilation would be futile.

The patient's daughter is insistent on continuing all forms of life support, including mechanical ventilation and even extracorporeal membranous oxygenation (ECMO) if indicated. However, Mrs. Ruth's delirium clears within the next 24 hours of intubation, and she is now competent, although still mechanically ventilated. She communicated to the ICU team that she preferred 1-way extubation (removal of the ventilator) and comfort care. This was communicated in writing to the ICU team and was consistent over time with other care providers. The patient went as far to demand the extubation over the next hour, which was felt to be reasonable by the ICU team.

The patient's daughter was informed of this decision and stated that she could not come to the hospital for 2 hours, and in the meantime, that the patient must remain intubated. At this point, the ICU team concurred with the patient's wishes, and extubated her before her daughter was able to come to the hospital.

The daughter was angry at the team's decision and requested that the patient be re-intubated if she deteriorated. When the daughter arrived at the hospital, the patient and daughter were able to converse, and the patient then agreed to re-intubation if she deteriorated.

1. Who do you think should make decisions in this situation? Should the ICU team have extubated the patient?

   Since Mrs. Ruth is completely aware of what is going on and is alert and oriented, she is capable to make medical decisions involving her care. As for the ICU team extubating the patient, I agree that it was the proper choice to follow the patients wishes but I would have mentioned to the patient of her daughters arrival time and allowed her to reevaluate her decision if she wished.

2. Do you think the patient should be allowed to change her mind?

   Yes, the patient should always be able to change their mind involving their care.

3. Does the change in the patient's decision mean that she lacked the capacity to make the decision in the first place, or that she was not well informed?

   I don't think she lacked the capacity to make decisions I just think she was ill informed. Family does have a huge impact on the decisions we make, especially ones involving life vs. death. Mrs. Ruth was not educated pre-intubation and her wishes were never discussed involving her medical care, I think all she needed was more education surrounding life-saving measures.

4. The patient's goals of care were not assessed preoperatively. When do you think would have been the ideal time to have that conversation with the patient?

   Since her procedure was urgent, she did not have the ideal time frame to discuss her goals of care. However, postoperatively (once recovered from anesthesia), the goals of care conversation should have happened with Mrs. Ruth just in case worse scenario happens (which it did). It is important to have these conversations so we are ahead of the game and know what the patient wants before it happens and honor those wishes. In this case it was not foreseen that Mrs. Ruth's care would decline like it did, but we had plenty of time before we reached this point to get all the necessary documentation needed to provide patient centered care.

Case 2 – Nutrition at the End of Life

Mrs. Green is a 75-year-old patient with renal failure, currently on dialysis, who also has COPD, moderate dementia, diabetes and a new diagnosis of stage one breast cancer. There is also a history of depression according to the family. She has been admitted to your ICU after falling down her stairs at home and is in critical condition with multiple fractures to her hip, ribs, wrists and neck. Mrs. Green does not have the capacity to make her own medical decisions and has recently started to refuse eating. Upon discussion with GI Specialists, the team agrees that the patient is not an appropriate candidate for a PEG (feeding) tube. The patient's daughter, who is her POA, insists that the you proceed with the placement of the PEG, stating that if the tube is not placed, she will contact her lawyer and proceed with legal action against the physician and hospital.

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1. What documentation would help you to determine what the patient's wishes are?
2. If the medical team does not feel that a PEG tube is medically appropriate, do you think the daughter can demand that it be placed and expect the team will provide it?
3. What do you think some complications of PEG tube feeding may be at end of life?
4. Families often struggle with the concept of stopping nutrition/hydration at the end of life. Why do you think that may be?